

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-037548

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9854** STATE FILE NUMBER

FILED OCT 10 1963

1. PLACE OF DEATH
a. ~~CHURCH~~ **City of St. Louis**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Mo.** b. COUNTY **Jefferson**

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis, Mo.** Length of stay in 1b

c. CITY OR TOWN **Festus, Mo.** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Firmin Desloge Hosp.** Inside Limits Yes No d. STREET ADDRESS (If outside, give location) **114 S. 4th.** Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
Joseph Fuller **9 30 63**

5. SEX **Male** 6. COLOR OR RACE **Colored** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **12-12-98** 9. AGE (last birthday) **63 yrs.** IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (City and state or country) **Mississippi** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **(Fuller,)** 13b. MOTHER'S MAIDEN NAME **(Thompson, Henrietta)** 14. NAME OF HUSBAND OR WIFE **Willie Mae**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT Address **Willie Mae Fuller 114 South 4th St. Festus Mo.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Arterio insufficiency**
DUE TO (b) **Generalized arteriosclerosis**
DUE TO (c) **Hypertension**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **421.1** PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **9-26-63** to **9-29-63** and last saw him alive on **9-29-63**. Death occurred at **10 15** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **G. Harry Robles, M.D.** 22b. ADDRESS **1325 No Grand** 22c. DATE SIGNED **10-2-63**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **10-6-1963** 23c. NAME OF CEMETERY OR CREMATORY **Greenwood Cemetery** 23d. LOCATION (City, town, or county) (State) **St. Louis (County) Missouri**

24. FUNERAL DIRECTOR ADDRESS **Ellis Funeral Home-2820 Stoddard St.** 25. DATE RECD. BY LOCAL REG. **OCT 3 1963** 26. REGISTRAR'S SIGNATURE **Paul Smith, M.D.**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Anton E. Larkin

Licensed Embalmer No. 4198

P. O. Address

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.